STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Testimony

Public Health Committee

March 20, 2013

Raised Bill No. 6588: AN ACT CONCERNING THE EXPIRATION OF CERTAIN HEALTH CARE PROVIDER CONTRACTS

Sen. Gerrantana, Rep. Johnson, Members of the Committee, the Insurance Department appreciates the opportunity to provide written testimony on Raised Bill No. 6588 - AN ACT CONCERNING THE EXPIRATION OF CERTAIN HEALTH CARE PROVIDER CONTRACTS. The bill would require hospitals and physician-hospital organizations, a term that is not defined in the proposal, to notify current patients ninety days in advance of a potential contract expiration.

The Department respectfully opposes House Bill 6588. However, the Department understands the concerns patients might have when there is the potential that their provider will not be able to reach a contract agreement with their insurer and the provider may no longer be included as a network provider.

The Department believes this bill is well intentioned, but if enacted, could create confusion and provides no consumer protections. The contract referenced on lines 13 of the bill does not indicate what contract is referred to in the bill; it merely states “expiration of such contract” without stating the other party to the contract. The assumption is that the bill is referring to a contract with an insurer or health care center, but that is not actually stated. Additionally, the notice provision has no requirement that the mandated notice be reviewed or approved by any regulatory authority to enforce the notice requirements or the timing. Finally, while unfortunately not always the case, most contract negotiations are actually resolved between providers and insurers and do not result in contract terminations. Therefore, this type of communication so far in advance of the expiration date could cause unnecessary concern for the members.

The bill further mandates that thirty days before the expiration of a contract between a hospital or a physician-hospital organization and an insurer, health care center or medical service corporation, the hospital or physician-hospital organization is required to seek a certification of its network adequacy from a national accrediting organization and submit that to the Insurance Commissioner. If the intent is to make sure that an insurer or health care center has an adequate network to service its membership should they terminate a hospital or major physician group, these requirements do not address that question and it is unlikely that these types of certifications could even been obtained by the terminated providers. The intent of requiring network adequacy certifications for medical providers who are no longer participating in insurance networks is unclear. Additionally, it is unclear why these would be submitted to the Insurance Commissioner who does not regulate providers.

The Department would like to bring to the Committee's attention the consumer protection oversight role the Insurance Department plays in protecting consumers when there is a potential for a hospital or large medical group to be terminated from an insurer or health care center provider network because a contract agreement cannot be reached over provider reimbursement rates. While the Department does not have regulatory authority over these contract negotiations between these parties, the Department has taken the stance that any domestic health care center or health insurer which utilizes networks and which may potentially terminate that provider from its network must advise the Department if it appears that the contract will be allowed to terminate. Under the Commissioner's existing statutory authority to protect the insurance consumers in Connecticut, the Department does require that our regulated entities submit to us for our review and approval a draft notice to all members and providers of the (1) the expiration date of such contract; (2) a statement that the hospital or physician-hospital organization may not be in-network after expiration of the contract; (3) information concerning transition of care procedures (4) contact information for the appropriate person or department the insurer, health care center. These letters must be approved by the Department prior to their being issued and the Department follows the publication of this notice with a requirement that the regulated entity update the Department regularly as to inquiries and transition of care requests. We have found that our regulated entities – the insurers and health care centers – have worked very well with us in these situations.

In addition, the Department does keep open a continuing dialogue with our regulated entity over the issue of network adequacy should the provider contract be terminated. The Department requires the regulated entity to confirm that the provider network will continue to meet NCQA or URAC adequacy requirements if the provider contract is terminated and if not, how the regulated entity plans to meet the adequacy requirements. While the Department does not have statutory authority over the network itself, section 38a-472f of the general statutes requires our regulated entities – health care centers and health insurers with networks - to meet NCQA or URAC network adequacy requirements and the Department monitors that requirement through an annual certification of network adequacy submitted to the Department by the regulated entity and Department confirmation when on site for Market Conduct exams.

We believe the requirements in Raised Bill 6588 would potentially undermine what we do and what we have worked so hard to accomplish and we ask that you reconsider their enactment.